



PHYSICIAN'S STATEMENT OF HEALTH

RN Name: _____

Please complete one of the following options

Option #1

The above named individual has been examined by me and found to be in good physical and mental health, free of communicable disease, and able to function without physical or mental limitations as a health care professional.

Printed Name of Physician

Signature of Physician

Date of Examination

Signature of Nurse _____ *Date* _____

Option #2

Fax current copy history and physical within the past 12 months signed by your Physician.

COPIES OF TEST RESULTS MUST BE ATTACHED TO BE VALID